BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **EMILY CHRISTINE MUHL** **127 Savory Lane** **North Wales, PA 19454** **Registered Nurse License No. 687522** RESPONDENT	Case No. 2011-803 **DEFAULT DECISION AND ORDER** [Gov. Code, §11520]

FINDINGS OF FACT

1. On or about March 23, 2011, Complainant Louise R. Bailey, M.Ed.,RN, in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs, filed Accusation No. 2011-803 against Emily Christine Muhl (Respondent) before the Board of Registered Nursing. (Accusation attached as Exhibit A.)

2. On or about August 25, 2006, the Board of Registered Nursing (Board) issued Registered Nurse License No. 687522 to Respondent. The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and expired on October 31, 2009 and has not been renewed.

3. On or about March 23, 2011, Respondent was served by Certified and First Class Mail copies of the Accusation No. 2011-803, Statement to Respondent, Notice of Defense, Request for Discovery, and Government Code sections 11507.5, 11507.6, and 11507.7 to Respondent's address of record which, pursuant to Business and Professions Code section 136 and/Title 16, California Code of Regulation, section 1409.1, is required to be reported and maintained with the Board, which was and is:

127 Savory Lane

North Wales, PA 19454.

4. Service of the Accusation was effective as a matter of law under the provisions of Government Code section 11505, subdivision (c) and/or Business & Professions Code section 124.

5. The notification from USPS track & Confirm search result indicates that on April 20, 2011 the Certified Mail documents were returned to North Wales, PA Post Office, marked as "Unclaimed" and was subsequently returned to the Sacramento, CA 94244 Post Office on April 25, 2011.

6. Business and Professions Code section 2764 states:

The lapsing or suspension of a license by operation of law or by order or decision of the board or a court of law, or the voluntary surrender of a license by a licentiate shall not deprive the board of jurisdiction to proceed with an investigation of or action or disciplinary proceeding against such license, or to render a decision suspending or revoking such license.

7. Government Code section 11506 states, in pertinent part:

(c) The respondent shall be entitled to a hearing on the merits if the respondent files a notice of defense, and the notice shall be deemed a specific denial of all parts of the accusation not expressly admitted. Failure to file a notice of defense shall constitute a waiver of respondent's right to a hearing, but the agency in its discretion may nevertheless grant a hearing.

8. Respondent failed to file a Notice of Defense within 15 days after service upon her of the Accusation, and therefore waived her right to a hearing on the merits of Accusation No. 2011-803.

9. California Government Code section 11520 states, in pertinent part:

(a) If the respondent either fails to file a notice of defense or to appear at the hearing, the agency may take action based upon the respondent's express admissions or upon other evidence and affidavits may be used as evidence without any notice to respondent.

10. Pursuant to its authority under Government Code section 11520, the Board after having reviewed the proof of service dated March 23, 2011, signed by Kami Pratab, finds Respondent is in default. The Board will take action without further hearing and, based on

Accusation No. 2011-803 and the documents contained in Default Decision Investigatory Evidence Packet in this matter which includes:

Exhibit 1: Pleadings offered for jurisdictional purposes;

Exhibit 2: License History Certification for Emily Christine Muhl, Registered Nurse License No. 687522;

Exhibit 3: Affidavit of Kevin Dutchover;

Exhibit 4: Certification of costs by Board for investigation and enforcement in Case No. 2011-803 and

Exhibit 5: Declaration of costs by Office of the Attorney General for prosecution of Case No. 2011-803

The Board finds that the charges and allegations in Accusation No. 2011-803 are separately and severally true and correct by clear and convincing evidence.

11. Taking official notice of Certification of Board Costs and the Declaration of Costs by the Office of the Attorney General contained in the Default Decision Investigatory Evidence Packet, pursuant to the Business and Professions Code section 125.3, it is hereby determined that the reasonable costs for Investigation and Enforcement in connection with the Accusation are $27,793.50 as of April 19, 2011.

DETERMINATION OF ISSUES

1. Based on the foregoing findings of fact, Respondent Emily Christine Muhl has subjected her following license(s) to discipline:

a. Registered Nurse License No. 687522

2. The agency has jurisdiction to adjudicate this case by default.

3. The Board of Registered Nursing is authorized to revoke Respondent's license(s) based upon the following violations alleged in the Accusation, which are supported by the evidence contained in the Default Decision Investigatory Evidence Packet in this case.

a. Violation of Business and Professions Code section 2761(a) - Unprofessional Conduct.

b. Violation of Business and Professions Code section 2761(d) - Violating or attempting to violate, directly, or assisting in or abetting the violating of, or conspiring to violate any provision or term of this chapter or regulations adopted pursuant to it.

c. Violation of Business and Professions Code section 2762(a) - Obtaining or possessing controlled substances without a prescription.

d. Violation of Business and Professions Code section 2762(b) - Use of controlled substance or alcohol to an extent or in a manner dangerous or injurious to oneself and others.

e. Violation of Business and Professions Code section 2762(e) - Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to a controlled substance.

ORDER

IT IS SO ORDERED that Registered Nurse License No. 687522, heretofore issued to Respondent Emily Christine Muhl, is revoked.

Pursuant to Government Code section 11520, subdivision (c), Respondent may serve a written motion requesting that the Decision be vacated and stating the grounds relied on within seven (7) days after service of the Decision on Respondent. The agency in its discretion may vacate the Decision and grant a hearing on a showing of good cause, as defined in the statute.

This Decision shall become effective on July 22, 2011.

It is so ORDERED June 23, 2011.

Jeannine K. Graves

JEANNINE K. GRAVES
President
Board of Registered Nursing
Department of Consumer Affairs

Attachment:

Exhibit A: Accusation No. 2011-803

Exhibit A

Accusation No. 2011-803

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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **EMILY CHRISTINE MUHL** **127 Savory Lane** **North Wales, PA 19454** **Registered Nurse License No. 687522** Respondent.	Case No. 2011-803 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., R.N. (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing (Board).

2. On or about August 25, 2006, the Board issued Registered Nurse License Number 687522 to Emily Christine Muhl (Respondent). The Registered Nurse License expired on October 31, 2009, and has not been renewed.

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JURISDICTION

3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Code section 2750 provides that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

6. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISIONS

7. Code section 2761 states:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct . . .
>
> . . .
>
> (d) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violating of, or conspiring to violate any provision or term of this chapter [the Nursing Practice Act] or regulations adopted pursuant to it.
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> . . .
>
> (f) Conviction of a felony or of any offense substantially related to the qualifications, functions, and duties of a registered nurse, in which event the record of the conviction shall be conclusive evidence thereof.
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8. Code section 2762 states:

In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

(b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.

. . .

(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

9. Code section 4022 provides:

"Dangerous drug" . . . means any drug or device unsafe for self use in humans or animals, and includes the following:

(a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without prescription," "Rx only," or words of similar import.

(b) Any device that bears the statement: "Caution: federal law restricts this device to sale by or on the order of a _____," "Rx only," or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.

(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006.

10. Code section 4059, subdivision (a), provides, in pertinent part, that "[n]o person shall furnish any dangerous drug, except upon the prescription of a physician . . ."

11. Code section 4060 provides, in pertinent part that "[n]o person shall possess any controlled substance, except that furnished to a person upon the prescription of a physician . . ."

12. Health and Safety Code section 11173, subdivision (a), provides:

> No person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation, or subterfuge; or (2) by concealment of a material fact.

COST RECOVERY

13. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DRUGS

14. **Ambien** is the brand name for Zolpidem and is a Schedule IV controlled substance pursuant to Health and Safety Code section 11056, subdivision (g), and a dangerous drug within the meaning of Business and Professions Code 4022.

15. **Fentanyl** is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c)(8), and a dangerous drug within the meaning of Code section 4022.

16. **Hydrocodone APAP** is the generic name for trade name drug Vicodin and is comprised of Hydrocodone Bitartrate (a semisynthetic opioid analgesic and antitussive) and Acetaminophen. It is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e)(3), and a dangerous drug pursuant to Business and Professions Code section 4022.

17. **Hydromorphone** is the generic name for the trade name drug Dilaudid. It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(K), and a dangerous drug within the meaning of Code section 4022.

18. **Lorazepam** is the generic name for the trade name drug Ativan. It is a Schedule IV controlled substance pursuant to Health and Safety Code Section 11057, subdivision (d)(13), and a dangerous drug within the meaning of Business and Professions Code section 4022. It is a benzodiazepine with CNS depressant, anxiolytic, and sedative properties.

19. **Morphine** is an opium derivative. It is a Schedule II controlled substance and narcotic as defined by Health and Safety Code section 11055, subdivision (b)(1)(M), and a "dangerous drug" pursuant to Business and Professions Code section 4022.

20. **Temazepam** is the generic name for the trade drug Restoril. It is a Schedule IV controlled substance and narcotic as defined by Health and Safety Code section 11057, subdivision (d)(24), and a "dangerous drug" pursuant to Business and Professions Code section 4022. It is generally prescribed for the short-term treatment of sleeplessness in patients who have difficulty maintaining sleep. In addition, temazepam has anti-anxiety, anticonvulsant, and skeletal muscle relaxant properties.

21. **Versed** is the trade name for the generic drug Midazolam. It is a Schedule IV controlled substance as designated by Health and Safety Code section 11057, subdivision (d)(13), and a dangerous drug within the meaning of Code section 4022. It is a benzodiazepine used for preoperative sedation.

FACTUAL SUMMARY

22. On or about August 7, 2001, Respondent began her employment Alta Bates Summit Medical Center in Oakland, California. From April 9, 2007, through January 21, 2009, Respondent worked as a registered nurse. Respondent resigned on January 21, 2009, with a disciplinary investigation pending.

23. After returning from medical leave in 2007 and again in 2009, coworkers reported that Respondent was acting as if she were under the influence of drugs.

24. During the course and scope of her employment, Respondent committed the following acts:

a. PATIENT 1[1]: On or about December 22, 2007, at 2206 hours and 2239 hours, Respondent removed one tablet Vicodin from the PYXIS[2] system to administer to Patient 1.

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[1] Patients are identified by numbers in order to preserve patient confidentiality. The medical record numbers of these patients will be disclosed pursuant to a request for discovery.

[2] PYXIS is a system for the automated dispensing and management of medications at the point of use in hospital settings.

Respondent failed to chart the administration of the medication, to chart wastage, or otherwise account for the medication.

b. PATIENT 2: On or about November 11, 2007, at 0430 hours and 0550 hours Patient 2's physician ordered the administration of .5 mg of Hydromorphone HCL. At approximately 0431 hours and 0555 hours, Respondent removed 2 mg of Hydromorphone HCL from the PYXIS system to administer to Patient 1. Respondent only chart the administration of .5 mg of the medication and failed to chart wastage or otherwise account for the remaining 1.5 mg of the medication.

c. PATIENT 3: On or about November 13, 2007, at 0425 hours, Patient 3's physician ordered 1 mg of Lorazepam. At 0422 hours, Respondent withdrew four 0.5 mg tablets of Lorazepam from the PYXIS system to administer to Patient 3. Respondent charted the administration of 1 mg the medication, but failed to chart wastage or otherwise account for the remaining 1 mg of the medication.

d. PATIENT 4: On or about December 7, 2007, at 0424 hours, Respondent withdrew 4 mg of Morphine from the PYXIS system to administer to Patient 4. Respondent charted the administration of the medication but there were no physician's orders for Morphine.

e. PATIENT 5: On or about November 9, 2007, at 1730 hours, Patient 5's physician ordered 2 tablets of Vicodin. At 1808 hours, Respondent withdrew 1 tablet of Vicodin from the PYXIS system to administer to Patient 5 and charted the administration. However, at 1818 hours, a different nurse charted the administration of 1 tablet of Vicodin.

f. PATIENT 6: On or about November 13, 2007, Patient 6's physician ordered 4 mg of Morphine every 20 minutes for reported pain levels greater than 5 out of 10, with a maximum of 20 mg.

At approximately 0039 hours, Respondent withdrew 4 mg of Morphine from the PYXIS system to administer to Patient 6. Respondent charted the administration of the medication but failed to chart the pain level of Patient 6.

At approximately 0129 hours, Respondent withdrew 4 mg of Morphine from the PYXIS system to administer to Patient 6. Respondent charted the administration of the medication and noted that Patient 6's pain level was 4 out of 10.

At approximately 0241 hours, Respondent withdrew 4 mg of Morphine from the PYXIS system to administer to Patient 6. Respondent charted the administration of the medication but failed to chart the pain level of Patient 6.

At approximately 0412 hours, Respondent withdrew 4 mg of Morphine from the PYXIS system to administer to Patient 6. Respondent charted the administration of the medication but failed to chart the pain level of Patient 6.

g. PATIENT 7: On or about January 20, 2008, at 1625 hours, Patient 7's physician ordered 1 mg of Hydromorphone HCL. At 2042 hours, Respondent withdrew 2 mg of Morphine Sulfate from the PYXIS system to administer to Patient 7. Respondent charted the administration of 1 mg of the medication but failed to chart wastage or otherwise account for the remaining 1 mg of the medication.

h. PATIENT 8: On or about January 12, 2008, at 1220 hours, Patient 8's physician ordered 2 mg of Versed. At 0032 hours, Respondent withdrew 2 mg of Versed from the PYXIS system to administer to Patient 8. Respondent failed to chart the administration of the medication, chart wastage, or otherwise account for the medication.

i. PATIENT 10: On or about November 13, 2007, at 0225 hours, Patient 10's physician ordered 1 mg of Lorazepam and stated that the dose could be repeated once as needed. At 0223 hours, Respondent withdrew 2 mg of Lorazepam from the PYXIS system to administer to Patient 10. At 0224 hours and 0320 hours, Respondent charted the administration of 1 mg of the medication. However, at 0320 hours, Respondent charted that Patient 10 was sleeping.

j. PATIENT 11: On or about December 19, 2007, at 0220 hours, Patient 11's physician ordered 1 mg of Lorazepam. At 0224 hours, Respondent withdrew 2 mg of Lorazepam from the PYXIS system to administer to Patient 11. Respondent charted the administration of 1 mg of the medication but failed to chart wastage or otherwise account for the remaining 1 mg of the medication.

k. PATIENT 15: On or about November 13, 2007, at 1435 hours, Patient 15's physician ordered 4 mg of Morphine every thirty minutes for pain greater than 5 out of 10. On or about November 13, 2007, at 0946 hours, Respondent withdrew 2 mg of Morphine from the PYXIS system to administer to Patient 15. However, at 1950 hours, Respondent charted that she administered Toradol and, at 1955 hours, she administered Levaquin to Patient 15. Respondent failed to chart the administration of the Morphine, chart wastage, or otherwise account for the medication.

l. PATIENT 16: On or about November 11, 2007, at 0120 hours, Patient 16's physician ordered 2 tablets of Vicodin. At 0130 hours, Respondent withdrew 1 tablet of Vicodin from the PYXIS system to administer to Patient 16. Respondent failed to chart the administration of the medication, chart wastage, or otherwise account for the medication.

m. PATIENT 18: On or about November 13, 2007 at 1900 hours, Patient 18's physician ordered 1 mg of Dilaudid. At 2001 hours, Respondent withdrew 1 tablet of Dilaudid from the PYXIS system to administer to Patient 18. Respondent failed to chart the administration of the medication, chart wastage, or otherwise account for the medication.

25. On or about January 1, 2008, at a Rite Aid Pharmacy in San Francisco, California, Respondent attempted to fill a falsified prescription for 30 tablets of Ambien CR 12.5 mg, 360 tablets of Dilaudid 8 mg, and 480 tablets of Lorazepam 2 mg.

26. On or about February 19, 21, 23, and 25, 2008, Respondent refilled prescriptions for 16 tablets of Hydrocodone 7.5 mg even though the original prescription, filled on February 13, 2008, prohibited refills.

27. On or about March 10, 2008, Respondent refilled a prescription for 20 tablets of Hydromorphone 8 mg despite the prescribing physician's 2006 prohibition of refills.

28. On or about April 27, 2009, Respondent submitted a falsified prescription for 580 tablets of Dilaudid 8 mg. The number of tablets on the written prescription had been modified without the prescribing physician's approval.

29. On or about March 2 and 3, 2008, Respondent submitted a prescription to Walgreen's Pharmacy in San Francisco, California for 10 tablets of Fentanyl 50 mcg, however, only one of the prescriptions was valid.

30. On or about March 10, 2008, Respondent submitted an invalid prescription to Walgreen's Pharmacy in San Francisco, California for 10 tablets of Fentanyl 50 mcg.

31. On or about March 30 and April 6, 2008, Respondent submitted a prescription to Walgreen's Pharmacy in San Francisco, California for 10 tablets of Fentanyl 75 mcg for early release without the physician's authorization.

32. On or about April 9, 2008, Respondent submitted an invalid prescription to Walgreen's Pharmacy in San Francisco, California for 10 tablets of Fentanyl 75 mcg.

33. On or about January 13, February 8 and 27, March 14, 17, and 30, April 5 and 23, May 2 and 27, June 15 and 27, July 5 and 22, August 27, and September 17, 2008, Respondent submitted prescriptions for 300 tablets of Hydrocodone APAP 325 mg for early release without the physician's authorization.

34. On or about October 8, November 19, and December 27, 2008, and January 7, 2009, Respondent submitted prescriptions for 360 tablets of Hydrocodone APAP 325 mg for early release without the physician's authorization.

35. On or about March 31, May 14, August 13, October 8, and November 19, 2008, Respondent submitted refill prescriptions for Lorazepam 2 mg for early release without the physician's authorization.

36. On or about September 4, 2008, Respondent submitted a refill request for a voided prescription for 120 tablets of Lorazepam 1 mg.

37. On or about June 10, 2008, October 8, 2008, and January 7 and 18, 2009, Respondent submitted refill prescriptions for Hydromorphone HCL 8 mg for early release without the physician's authorization.

38. On or about March 14, 17, and 29, April 9 and 23, May 9 and 14, August 13, and September 4, 2008, Respondent submitted refill prescriptions for 30 caplets of Temazepam 30 mg for early release without the physician's authorization.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct)
(Business and Professions Code §2761(a))

39. Respondent has subjected her registered nursing license to discipline under Code section 2761, subdivision (a)(1), for unprofessional conduct, as defined by California Code of Regulations, title 16, section 1442, in that she committed acts of unprofessional conduct in carrying out her usual certified or licensed nursing functions. On the occasions more particularly set forth in Paragraphs 22-38, above, she committed the following acts:

a. Administered narcotic medications to patients without proper documentation;

c. Administered narcotic medications to patients at incorrect intervals;

d. Failed to properly chart the administration of medication to patients, chart wastage or otherwise account for medication; and

e. Filled personal prescriptions early and filled a voided prescription.

SECOND CAUSE FOR DISCIPLINE

(Obtaining and/or Possessing Controlled Substances or Dangerous Drugs)
(Business and Professions Code §§ 2761(a) and 2762(a))

14. Respondent has subjected her registered nursing license to discipline under Code section 2761, subdivision (a), for unprofessional conduct, as defined by Code section 2762, subdivision (a), in that she obtained controlled substances and dangerous drugs by fraud, deceit, misrepresentation, subterfuge, and/or by the concealment of a material fact, in violation of Health and Safety Code section 11173, subdivision (a), as set forth in paragraphs 22-38, above.

THIRD CAUSE FOR DISCIPLINE

(Use of a Controlled Substance and Dangerous Drug)
(Business and Professions Code §§ 2761(a) and 2762(b))

40. Respondent has subjected her registered nursing license to discipline under Code section 2761, subdivision (a), for unprofessional conduct, as defined by Code section 2762, subdivision (b), in that from on or about 2007 through 2009, Respondent used controlled substances and dangerous drugs, to an extent or in a manner dangerous or injurious to herself, any

other person, or the public and to the extent that such use impaired her ability to conduct herself safely in regard to the public, as more particularly described in Paragraphs 22-38, above.

FOURTH CAUSE FOR DISCIPLINE

(Falsified or Incorrect or Inconsistent Entries in Records)
(Business and Professions Code §§ 2761(a) and 2762(e))

41. Respondent has subjected her registered nursing license to discipline under Code section 2761, subdivision (a), for unprofessional conduct, as defined by Code section 2761, subdivision (e), and Health and Safety Code section 11190, in that while employed as a registered nurse at Alta Bates Summit Medical Center in Oakland, California, she made false, grossly incorrect, and/or grossly inconsistent entries in hospital, patient, or other records pertaining to controlled substances and dangerous drugs as set forth in Paragraphs 22-24, above.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters alleged in this Accusation, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 687522, issued to Emily Christine Muhl;

2. Ordering Emily Christine Muhl to pay the Board the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and

3. Taking such other and further action as deemed necessary and proper.

DATED: 3/23/11

Louise R. Bailey

LOUISE R. BAILEY, M.ED., R.N.
Executive Officer
Board of Registered Nursing
State of California
Complainant

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